Easy Travel Insurance
Proposal Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Application No. : _____

We are under no obligation to accept any proposal for insurance. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and in time, or is not realised. Please fill-up this form in CAPITAL LETTERS.

PROPOSER DETAILS

Proposer : (Mr./Ms./Mrs.)			
First Name	Middle name		Last Name
Address:			
Landmark:			
City/Town:	District:		
State:		PIN Code:	
E- Mail:			
Contact details (India):	Contact details (Overseas):		

Nationality : _____

Profession : Salaried ☐ Self Employed ☐ Others ☐ Details _____

Occupation (nature of duties) : _____

PLAN DETAIL(S) (Please refer to the brochure for details of benefits under plans & select the appropriate option below)

Type: Individual ☐ Family ☐ Senior Citizen ☐ Annual Multi-trip 30 days ☐ Annual Multi-trip 60 days ☐

Plan: Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Asian Region ☐

Geography: Worldwide ☐ Worldwide excluding USA & Canada ☐ Asia Pacific excluding Japan ☐

Proposed Policy Period : From D D M M Y Y Y Y To D D M M Y Y Y Y

PROPOSED INSURED(S) DETAILS: Name of the persons proposed to be insured (including Proposer)

S No.	Mr./Ms./Mrs. Name of the person to be insured	Relationship to the Proposer	Gender* M/F	Date of Birth (DDMMYY)	Passport Number
1					
2					
3					
4					
5					
6					

*Gender code M (Male), F (Female)

NOMINEE DETAILS

In the event of the death of an Insured Person any payment due under the Policy will be payable to the Nominee in accordance with the Policy terms and conditions. Please give below the details of the Nominee, who must be an immediate relative of the Proposer. Nominee for all other persons proposed to be insured shall be the Proposer

Nominee Name	Relationship to the Proposer	Address of the Nominee

EXISTING INSURANCE DETAILS

Is the proposer or any of the persons proposed, already insured under or proposed for a personal accident insurance policy with Apollo Munich Health or any other insurance company? If yes, please indicate below the Policy/Application number(s) (Please mention application number incase of pending proposal):

Policy No. / Application No.	Insurer	From (Date)	To (Date)	Sum Insured
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	
		D D M M Y Y	D D M M Y Y	

MEDICAL & LIFE STYLE INFORMATION (if your answer to any of the below is 'yes', kindly attach the details in an extra sheet duly signed)

Are You suffering from or have You ever suffered from any of the following (please encircle): arthritis, allergies, circulatory disorder, cancer of any kind, diabetes, disorders of the spinal cord or vertebral column like slipped disc etc, disorders of the stomach / large or small intestine, high blood pressure, heart condition, hernia of any kind, hemorrhoids, hematological (blood) disorder, mental condition, nervous disorder, fainting episode, blackouts, fits, paralysis of any kind, respiratory disorder, urinary disorder, varicose veins or any diseases or injury requiring surgical or medical treatment.

If Your answer is 'yes' to any of the above, please provide details : _____

Easy Travel Insurance
Proposal Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

Please provide name and contact details of Your treating or family doctor : _____

_____

_____

PAYMENT DETAILS

Instrument type Cash/Cheque/Debit/Credit Card/ Others	Instrument No.	Bank Details	Date	Amount (in Rs)

Please make a crossed cheque/DD/Pay Order in favour of 'Apollo Munich Health Insurance Company Limited'only.

Section 41 of Insurance Act 1938 as amended by Insurance Laws Amendment Act, 2015 (Prohibition of Rebates):

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurers. Any person making default in complying with the provision of this section shall be liable for a penalty which may extend to 10 lakh rupees.

ADDITIONAL INFORMATION

[If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach a separate sheet to this proposal and return it to us.]

GENERAL EXCLUSIONS

Following is an outline of the exclusions under the policy. Specific additional exclusions apply to various benefits under the policy. For more details on the exclusions & waiting periods please refer the policy wordings before purchasing this policy.

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy: War, war like operations; nuclear weapons/materials radiation of any kind; committing or attempting to commit a criminal or unlawful act; participation or involvement in naval, military or air force operation or any hazardous ; abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as drugs and alcohol; treatment of nicotine addiction or any other substance abuse; intentional self injury or attempted suicide; obesity/morbid obesity and any weight control program; "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human immunodeficiency virus), venereal disease, sexually transmitted disease; pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness) except in the case of ectopic pregnancy; non allopathic treatment; charges related to a Hospital stay not expressively mentioned as being covered; Personal comfort and convenience items, vitamins and tonics; treatments rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; out-station consultations and referral-fees; treatments by a Medical Practitioner who shares the same residence as an Insured or a member of an Insured Person's Family; the provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy; any treatment and associated expenses for alopecia, baldness, diabetic test strips, and similar products; any treatment that is not medically necessary; where purpose of travel is to obtain medical treatment; treatment of any pre-existing condition, cancer, orthopedic, degenerative or oncology diseases unless to save life in an unforeseen emergency or to relieve acute pain; cosmetic treatment; congenital internal or external disease.

This proposal will be the basis of any insurance policy that we may issue. You must disclose all facts relevant to all persons proposed to be insured that may affect our decision to issue a policy or its terms. Non-compliance may result in the avoidance of the policy. If there is insufficient space for you to provide information, whether as requested or otherwise, please attach a separate sheet. If you are in doubt, please seek the advice of your insurance advisor.

DECLARATION & WARRANTY ON BEHALF OF ALL THE PERSONS PROPOSED TO BE INSURED

- ☐ I/ We hereby declare, on my behalf and on behalf of all persons proposed to be insured that the above statements, answers and/or particulars given by me are true and complete in all respects to the best of my knowledge and that I/We am/ are authorized to propose on behalf of these other persons.
- ☐ I understand that the information provided by me will form the basis of insurance policy, is subject to the Board approved underwriting policy of the Insurance company and that the policy will come into force only after full receipt of the premium chargeable.
- ☐ I/ We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/ proposer after the proposal has been submitted but before communication of the risk acceptance by the company.
- ☐ I/We declare and consent to the company seeking medical information from any hospital who at anytime has attended on the life to be insured/ proposer or from any past or present employer concerning anything which affects the physical and mental health of the life to be assured/proposer and seeking information from any insurance company to which an application for insurance on the life to be assured/ proposer has been made for the purpose of underwriting the proposal and/or claim settlement.
- ☐ I/ We authorize the company to share information pertaining to my proposal including the medical records for the sole purpose of proposal underwriting and/or claims settlement and with any Governmental and/or Regulatory Authority.

Signature of the Proposer: _____ Signature of the Advisor: _____

Date: Place:

Insurance is the subject matter of solicitation

FOR OFFICE USE ONLY

Apollo Munich Health Office Code	:		Advisors Code & Name :	
Branch Receipt Date	:		Channel Type :	
Business Type	:	Urban/ Rural/ Social		

Easy Travel Insurance

NEFT details

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

Mandatory details required to process all payment due in relation to your policy including refunds (if any) and / or claims directly to your bank account

Please select any one of the below options

I hereby declare that below bank details are correct and should be used to process all payment due in relation to my insurance policy:

- ☐ Bank account details as mentioned on the cheque* being submitted along with the Proposal Form towards premium payment for insurance Policy should be used by the Company for electronic fund transfer as mode of payment.
- ☐ I do not have any existing bank account. I agree to open a bank account and provide my bank account details to the Company for electronic fund transfer as mode of payment. I shall provide these details before renewal of my insurance policy or before any payment becomes due in relation to my insurance policy (whichever is earlier). I understand that as per regulatory requirement, Company shall process any payment in relation to my insurance policy only through electronic fund transfer after receipt of aforesaid pending bank details from me.
- ☐ Bank account details as provided below and for which I am submitting a cancelled cheque, should be used by the Company for electronic fund transfer as mode of payment. (Cancelled Cheque should be of the same bank account in which the refund needs to be credited directly)

Particulars of Bank Account:

Name as in Bank Account:																							
Bank Name:																							
Bank Branch:								Bank Account Number:															
MICR No. :										IFSC Code:													

I agree and undertake to intimate in writing to Apollo Munich about any change in bank account details. I also hereby certify that the particulars furnished above are correct to the best of my knowledge.

Proposer/Policy holder's Signature

Date : D D M M Y Y

DISCLAIMER: APOLLO MUNICH shall not be liable to anybody, in any manner, whatsoever if the NEFT transaction does not complete for any reason whatsoever including without limitation- failure on part of the Bank/s involved to perform any of their obligations for aforesaid NEFT transaction or incomplete/incorrect information by Customer/Policy Holder. Aforesaid NEFT transaction shall be governed by applicable Reserve Bank of India rules, directions & guidelines and shall be subject to participating Bank user terms and conditions related to NEFT facility. Apollo Munich shall be indemnified against any loss/damage/claims caused to Apollo Munich in carrying out your aforesaid NEFT instructions.

Instructions:

- It is important for these electronic payment systems that the Policy Holder's name in the Policy must exactly match with the name in the Bank Account records/ details given above.
- In cases where beneficiary's bank account number & name is printed on the cheque, bank attestation is not required. For all other cases bank attested NEFT mandate is required.
- The customer who is willing to transfer the funds will be required to provide the 11 digits valid IFS Code, which is applicable for NEFT only. (a number allotted to each participating banks branch) of the branch where the funds need to be transferred.
- Cancelled cheque should be attached along with the NEFT format.
- In case cancelled blank cheque does not bear account holder's name, please provide photocopy of bank statement / passbook with latest entries updated or else Bank attestation is required
- NEFT Form needs to be complete in all respect.

*** in case the premium payment cheque does not have all the details required for electronic fund transfer, please fill the above table**

AMHI/PR/H/0003/0007/102010/P

ET/PF/V0.03/062016

Easy Travel Insurance

Acknowledgement

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

Application No : _____ Date : _____

Name of Proposer : _____

We acknowledge with thanks the receipt of your application and amount by cash/cheque/Demand Draft/others _____ of amount of Rs. _____.

Neither the submission to us of a completed proposal for insurance nor any payment for any policy sought obliges us to agree to issue a policy, which decision is and always shall be in our sole and absolute discretion. If we accept a proposal for insurance, it shall be subject to the policy terms and conditions and we shall have no liability to make any payment if premium is not received by us in full and in time, or is not realised. If we do not accept the proposal, we will inform you and refund any payment received from you without interest within next 30 days.

Signature of the receiver and official seal

We would be happy to assist you. For any help contact us at: Email: customerservice@apollomunichinsurance.com Toll Free: 1800 102 0333